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# Incorporating E-Therapy into Practice, Social Worker Perspectives

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Incorporating E-Therapy into Practice,  
Social Worker Perspectives

By

Kristine Strobl-Reichel, B.S.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

**Abstract**

Access to mental health services locally, nationally, and globally is a challenge. E-therapy is an appealing avenue to offer services to underserved and stigmatized clients. While an interesting new therapy modality, numerous questions and concerns are raised in the literature regarding online therapy services.

This study sought to answer the research question, what factors influenced a provider's decision to provide online therapy? This qualitative study recruited clinical social workers providing E-therapy. Questions were designed to shed light on the development of a therapeutic connection, insurance coverage and reimbursement, technology glitches, and client inappropriateness for E-therapy treatment.

Findings for this study highlighted E-therapy offering increased flexibility of services for clients and providers alike. Providers cited lowered costs by using free video services and no brick and mortar overhead. Insurance coverage is extremely limited and typically self-pay. Security was raised as an issue of concern and consent regarding the acknowledgement of current security deficiencies. A therapeutic connection can be established in this format, however providers did agree that severe and persistent mental illness diagnoses are not appropriate for an E-therapy treatment environment. Concerns regarding licensing for E-therapy services to limit service delivery to within a licensed state were raised. The inability to have a high-speed Internet connection is an issue keeping many underserved clients from this therapy format. Implications for practice include provider boundaries, E-therapy training, and technological expertise by providers. Policy considerations include state and national initiatives to increase high-speed Internet access.

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### **Introduction**

Traditional face-to-face psychotherapy has been around for over a century and is now being upended by the Internet. Internet capabilities have been increasing exponentially over the past decade, or more and web-based therapy, and self-help is much more feasible. Gone are the days of Freud's hand written correspondence to diagnose and treat mental illness (Prabhakar, 2013). Now clients want instant access to their therapist in a variety of formats. "I'm in town, let's meet in-person." "I'm traveling, lets video chat." "I'm in a crisis, let me text you."

While increased accessibility and choice of mental health services by clients is ideal, this new format does open new doors to the need for additional client protections. Is hanging out your virtual shingle too easy? How do you know if the therapist is who they say they are? How do you know if their license is what they say it is? Some states offer an online license verification program, does yours? License verification is only part of the question, is the provider in the same state as you? If not, does their out of state license work?

In our fast paced, time-crunched society there are many reasons to choose online therapy instead of in-person. The sheer time savings of not driving to an appointment, sitting in a waiting room (the stigma of being recognized), plus the session time and driving back to home, work or the next event. This can be overwhelming even when personal transportation is an option. If you don't have a reliable vehicle, as many people don't, you depend on public transportation, friends, or family to drive you. Scheduling can be challenging enough between you and the therapist, but add in another schedule and it might be the tipping point to drop out of therapy.

Many of today's working poor do not have adequate sick or personal time off available to them. According to the Bureau of Labor Statistics data from March 2014, only 24% of part-time employees have access to sick leave. Schedules often vary from week to week and schedules are not posted more than 2 to 4 weeks in advance. These scheduling constraints affect many nurses, flight attendants and other hourly workers such as those working in retail. Online therapy options alleviate geographic constraints for over the road truckers or college students. Requesting time off in advance may result in lower hours and less take home pay. When your budgetary margins are tight, choosing therapy is a hard choice.

Research from 2003 shows people are choosing to be "online" and spend a significant amount of time in an electronic environment for work, shopping, and information. Mental health services are becoming no different (Castelnuovo, Gaggioli, Mantovani, and Riva, 2003).

### **Mental Health Impact**

In the United States, approximately 61.5 million people suffer from mental illness annually. Nearly 14 million people are diagnosed with a serious mental illness such as schizophrenia, bi-polar disorder or major depression. Almost half of homeless adults in shelters have a co-occurring substance use disorder and serious mental illness (NAMI, n.d.).

The tenth leading cause of death in the United States, according to the National Alliance on Mental Illness is suicide. This death rate is higher than from homicides. Of the people who complete suicide, over 90% had one, if not, multiple mental disorders. The most common cause of hospitalizations for ages 18 to 44 are mood disorders such as



depression. The life expectancy of people diagnosed with mental illness is nearly 20 years less than a person without mental illness (Thornicroft & Tansella, 2013).

### **Mental Health Treatment Barriers**

In order to adequately allocate mental health resources to increase effective treatment it is important to understand what barriers exist to mental health services and treatment (Andrade et al., 2014). According to World Health Organization (WHO) research a majority of people diagnosed with mental illness receive no treatment (Thornicroft & Tansella, 2013). Further WHO research identifies attitude barriers to seeking mental health treatment such as, negative experiences with previous providers and a lack of confidence in a provider's ability to treat the presenting problem (Andrade et al., 2014).

### **Study**

This study will consist of in-person interviews with eight to ten social workers in clinical practice. The sample of providers must use online therapy in their direct practice. This purposive sampling decision allows this researcher to interview people with firsthand knowledge of online therapy usage.

Informed consent will be obtained at the interview. The study does not have any inherent risks or benefits to participating. The interview will take place in a private location to ensure the confidentiality of the subject matter. The interview is expected to be between 60-75 minutes in length. The questionnaire includes nine questions, and a majority of those have additional clarifying questions.

Themes and concepts from the interviews will be compiled into a coding book. This information will form the basis of data to answer the research question: What factors influence a provider's decision to provide online therapy.

### **Literature Review**

In our growing digital age clients are seeking health information via the Internet. A 2010 article by Horgan & Sweeney highlights 47% of Irish people have used the Internet to obtain medical information. This research also found large numbers of people in the US, Canada, and Europe exploring the growing numbers of medical websites for health information. Clients who are searching, specifically, for mental health information is also growing according to this same study.

Despite initial opposition and skepticism to online therapy services by providers and the public, it has gained ground in viability and acceptance (Barak, Klein, Proudfoot, 2009). This new field of mental health delivery is referred to by many different names, e-therapy, online therapy, telepsychology, cybertherapy, web-based therapy, and computer-mediated interventions (Barak et al., 2009). Improvements in Internet bandwidth have vastly improved the viability of real time audio and video options. This has enabled expansions of the telepsychiatry and teletherapy services (Alcaniz, Botella, Banos, Zaragoza & Guixeres, 2009). Telehealth, the marriage of technology and mental health is defined as “the use of telecommunications and information technologies to provide access to health information, assessment, diagnosis, intervention, consultation, supervision, education and follow-up programs across geographical distance (Castelnuovo, Gaglioli, Mantovani, & Giuseppi, 2003).

Barak & Grohol’s 2011 research sees the future of e-therapy as providing vastly more effective mental health resources to the general public than ever before. Previously, advertising campaigns educated the public about mental illness, but it did not offer mass market treatment options. Online therapy, self-guided treatments can provide that additional level of resource and client support. Ultimately, if clients seek out symptom

diagnosis early and begins treatment sooner rather than later the disease burden could be lessened.

Information gathered by Alleman in 2001 showed that a high percentage of surveyed clients who started their therapy services online not only found it beneficial, but indicated they would not have begun services if face-to-face was the only option available. Further information indicated many of these clients would now choose to continue therapy services face-to-face.

Treatment of most moderate levels of mental illness such as anxiety disorder, social phobias, body image, shame and guilt, agoraphobia, adult children of alcoholics are believed to be appropriately treated using e-therapy by Alleman, 2002. Use of new electronic technology by social workers, in particular, allows this profession to continue to meet clients where they are (Wodarski & Frimpong).

### **Societal/economic burden**

Effective mental health treatment exists, yet is unavailable to many people worldwide. Andersson, Moore, Hensing, Krantz, Staland-Nyman in 2014 note that the prevalence of mental health disorders in the European Union is one in four people. This figure is similar to rates reported in the United States which equate to approximately 61.5 million people afflicted (NAMI, n.d.). According to the WHO, the amount of mental health treatment available subtracted from the diagnosed population of a mental disorder is the gap in mental health treatment (Kohn, Saxena, Levav, Saraceno, 2003). The impact of mental illness on people and communities is striking. The people affected are often disabled as a result of their mental illness, which creates economic hardships for the family and the community who ends up supporting them through a social program. Kohn, et al., 2003 cite several reasons for increased level of disability related to a client's

mental health disorder, early onset of diagnosis coupled with delayed start of treatment, lack of ongoing specialty mental health care, electing not to seek treatment because clients did not have adequate information on their mental health disorder and believed the condition would go away on its own (Kohn et al., 2003; Andrade et al., 2013, Andersson et al., 2014), the financial burden of treatment (Andrade et al., 2013), desire to overcome the problem on their own (Andersson et al., 2014), or not believing mental health treatment would be effective (Kohn et al. 2003; Andrade, et al., 2013), and stigma (Kohn et al., 2003; Andrade et al., 2013). Andrade et al., 2013 found that self-stigma and social labeling were also negatively correlated with seeking out or sticking with treatment.

Of people who identified their need for services, the second highest reason cited for not choosing services was, they wanted to handle the problem on their own (Andrade et al., 2013). Negative public attitudes and fear of workplace discrimination contributed to people not seeking treatment (Andrade et al., 2013). This negatively contributes to the economic environment, as the afflicted are more likely to call in sick and ultimately be removed from the workforce receiving income from a social program instead of working. Data from WHO surveys in 24 countries highlight additional barriers to clients seeking mental health treatment such as attitude barriers were identified as problematic for mild to moderate cases and structural barriers negatively influenced treatment for severe cases. According to research by Barak & Grohol in 2011, two-thirds of people with a diagnosable mental illness do not choose treatment. There are many reasons clients are unable or unwilling to seek mental health treatment. Many include distance to the nearest provider, travel conditions, disability of the client (Rummell & Joyce, 2010; Menon & Rubin, 2011).

**Benefits of e-therapy****Access**

Electronic therapy offers treatment options where none previously existed. Online treatment can begin the journey to mental health services for clients previously unwilling to seek treatment (Heinlen, Welfel, Richmond & Rak, 2003; Rummell & Joyce, 2010). These online services can offer additional support for existing in-person therapy (Wodarski & Frimpong, 2013).

Increasing access to mental health services is an ongoing concern. Rural areas are particularly affected by a lack of mental health professionals and e-therapy offers a possible solution (Castelnuovo et al., 2003; Heinlen, Welfel, Richmond and Rak, 2003; Menon & Rubin, 2011). According to the Bureau of Labor Statistics, in 2010, nearly 90 million people in the US are in a Mental Health Professional Shortage Area (Kliff, 2012). Electronic access to a therapist, psychiatrist or other mental health professional is a step ahead of no access (Wodarski & Frimpong, 2013).

Barak, et al., 2009 research highlighted the potential irrelevance of in-person office appointments. Therapy appointments can be scheduled at times more convenient to clients, from any distance, in a location of the clients choice, no longer dictated by the therapists physical space. Attending your therapy appointment from the comfort of your couch has a certain appeal. The ability to have a session after your work hours without travel time can make therapy more realistic for many working people.

Allowing clients therapeutic options and freedom to choose what is right for their lifestyle can strengthen the therapeutic alliance as much or more than through face-to-face therapy alliances as found by Barak & Grohol, 2011. New advancements in technology allow clients to research therapists through web sites based on Internet

searches. Entire virtual clinics exist offering clients the opportunity to compare provider profiles, costs, and schedules.

Recent advances in online therapy availability allow access from more diverse populations than previously before (Barak & Grohol, 2011). Client access to multicultural counselors is also more viable using online therapy services (Elleven and Allen, 2004).

### **Convenience and choice**

Receiving help from a provider specializing in a clients presenting problem is also key. All mental health providers are not specialized in every disorder and treatment by someone qualified increases positive treatment outcomes. Electronic therapy can cross the geographic boundaries separating a client from the specialist they need to assist them.

### **Efficacy of treatment**

Efficacy of e-therapy to treat many different mental health diagnoses has been studied since the early 2000's. Carlbring et al, and Klein, Richards & Austin found panic disorder symptom reduction via Internet based client administered programs with minimal therapist involvement. The self-report scales of participants versus the control or wait list group showed significant symptom improvement (Carlbring and Klein et al. 2005). Overall life satisfaction improved for clients suffering from panic disorder according to Carlbring et al. This efficacy coupled with increased therapist caseload capacity positively impacts client access to effective mental health services.

Klein et al., 2005 found client perceived e-therapy efficacy positively influenced treatment outcomes. Barak, Hen et al (2008) and Barak, et al. (2009) found no difference in treatment effectiveness when delivered either face-to-face or online. Research also found positive gains when treatment is a combination of in-person and online therapy

interventions (Cardenas, Serrano, Flores and De la Rosa, 2008). This supports the assertion that online therapy can produce results as effective as in-person.

### **Therapeutic Relationship**

Lack of non-verbal cues is a consistently identified concern about online therapy. Previous research theorizes that humans create and expand nonverbal cue substitutes when we are cut off from the traditional socioemotional cues. The words people choose to use and the way they construct sentences or phrases conveys warmth, comfort, compassion, and caring. Using a written form of communication does not mean we are limited in our expressiveness (Alleman 2002), this has been proven over thousands of years of letters, plays and personal writings. Today's text or instant message words may be as difficult to understand to future generations as Shakespeare is to today's readers.

Wodarski and Frimpong's 2013 research noted that clients were as willing to open up and provide personal information to in-person therapists as e-therapists. The hyperpersonal communication theory suggests clients can have an interaction online which exceeds that of face-to-face interactions. Reasons for this hyperpersonal interaction (Walther, 1996, cited by Alleman 2002) can include clients creating an idealized image of their therapist, and the online disinhibition effect which contributes to clients sharing personal information sooner than they would in face-to-face therapy (Alleman, 2002). Disinhibition highlights the different ways people act when they believe they are anonymous. This effect can contribute to very inconsistent behavior, someone who volunteers for impoverished charities yet participates in online posts espousing hateful comments about the poor.

The therapeutic relationship was found to be intact by e-therapy participants who believed the treatment modality would be effective (Klein et al., 2005). Qualitative and

quantitative research supports the therapeutic alliance is similar in online therapy as it is in in-person therapy (Barak and Grohol, 2011; Barak et al., 2009).

Online communication can be used misused by either provider or client. Professional boundaries must be adhered to even when the ease of connecting with one another can contribute to a blurring of the professional and personal relationship. Training on the appropriate use of each method to provide professional guidance on developing and adhering to a professional code of professional behavior would benefit all parties (Barak et al., 2009).

Alleman, 2002 indicated that clients expressed themselves more confidently, were less inhibited using an online medium versus face-to-face. Therapists also reported they responded to client issues in a more focused, empowered manner than on the spot with a client sitting across from them. Clients and therapists can choose which signals and cues to use in-person or online. If either party deliberately wants to mislead the other person with false cues that is always possible.

### **Cost effectiveness**

A study highlighted by Wodarski & Frimpong, 2013 noted Internet CBT therapy was more effective than traditional CBT when addressing therapist time. Higher caseloads reduce overall cost and Internet CBT was even more cost effective than traditional CBT group therapy.

Agencies providing in-home therapy services can see a large cost reduction by implementing Internet therapy (Wodarski & Frimpong, 2013). The travel reduction time savings can translate to more appointment access and more services provided.

Studies have shown cost savings while using computerized CBT interventions during substance abuse treatment (Barak & Grohol, 2011). A study regarding



computerized interventions with brain injury patients found similar outcomes and costs to traditional interventions (Barak & Grohol, 2011). Social phobia treatment utilizing a combination of email support and web applications found highly effective outcomes while seeing a cost savings over traditional interventions (Barak & Grohol, 2011). In a depression intervention study measuring both cost-utility and cost-effectiveness online services contributed to significant benefits for both measures (Barak & Grohol, 2011).

One study did raise questions regarding overall cost-effectiveness as it's therapist involvement and availability that usually translates to better outcomes (Barak & Grohol, 2011). Maheu (2003) indicated lack of streamlined and established data metric to measure cost-effectiveness is hampering reimbursement.

### **E-therapy modalities**

#### **Email.**

Email is the most common form of therapy intervention. These communications are either sent in an asynchronous format, not at the same time, or synchronous emails sent simultaneously, similar to texting. It's been found to be more convenient for clients to email and cheaper than a video session. Providers are able to monitor their clients' symptoms more closely with multiple check-ins a week, if needed. This allows clients to contact the provider when they need therapist support, not just during a session. If clients are feeling symptomatic they have the opportunity to monitor their behavior and send an email update. Clients may try out a new therapy skill and report back so they document things when they are fresh (Castelnuovo et al., 2003). This may solidify the connection between therapy in session and in practice for clients. Therapy is not a passive process and opportunities to practice their skills on a daily basis increases that connection.

Client care team collaboration is also easier and more effective using online tools such as email. Also sending clients web links, homework or resource information can be done outside of the therapy session, saving valuable appointment time. Providers can also send the same resources to additional clients after the initial data gathering (Maheu, 2003).

Written communication skills are necessary to navigate online therapy. Both providers and clients need to express their thoughts and feelings as clearly as possible. This is a different challenge without verbal cues. The use of punctuation, !!!, capitalization, I CANNOT believe this happened today or wOw, word spacing, I am functioning s-l-o-w-l-y today, also emoticons, ☺, provide some additional emotional context to words. Thoughts ideally are expressed without a significant amount of back and forth clarification which would drag down the process and perhaps dilute the effectiveness of online therapy (Barak et al., 2009).

A downside is these exchanges do lack some verbal communication cues. To combat this, cognitive behavioral and solution-focused therapy techniques have been co-opted for online use (Barak & Grohol, 2011). However, providers may not recognize crisis symptoms in an email format. Another concern is providers not responding in a timely manner, which may disappointment clients and possibly exacerbate their symptoms (Castelnuovo et al., 2003). Maheu's 2003 research indicated some clinicians do not want to squeeze in another unreimbursed task between sessions. Email could allow clients to send information to the therapist to add to the next session agenda and it's no longer their responsibility.

**Video chat or teleconference.**

This online therapy format is most similar to traditional face-to-face psychotherapy. Patient acceptance of this method has developed very quickly since client and provider can see and hear each other and communicate in real time. This modality is seen as a benefit to rural populations who are without mental health providers or are only seen in an emergency situation, not regularly. Video conferencing is more accessible as broadband Internet capabilities have increased throughout the United States. (Castelnuovo et al., 2003). Assessments via videochat allow providers the best opportunity to accurately assess the presence or absence of diagnostic criteria, especially in more severely mentally ill clients (Maheu, 2003).

**Self-guided or self-help.**

Some self-help or self-guided services are offered free of charge or at a significantly reduced cost than traditional or e-therapy options. This can provide a treatment option to clients who otherwise could not afford mental health treatment (Wodarski & Frimpong, 2013). Cost savings and treatment choice translates to increased access.

Barak et al in 2009 described these programs as prescriptive interventions designed for behavior modification. These typically offer education content or a therapeutic change. Several different options are available to providers such as web-based sites offering videos, information content, and photos. Interactive online programs offer active client participation to gain content and skills. This option could include tracking symptoms to chart progress using therapeutic skills. This offers more client engagement than static content only sites. Supportive feedback in the form of a generated email, sent with varying degrees of frequency and content. These emails can

be autogenerated by the computer or sent by a mental health professional and are another way to guide a client through therapeutic interventions and processes.

Additional therapeutic gains are seen when self-guided treatments are combined with text message or smart phone support. This enables clients to use the service wherever they are and practice the therapeutic tools (Wodarski & Frimpong, 2013).

### **Virtual reality**

This treatment modality began in 1992 and the efficacy has been proven for phobia treatment (Alcaniz et al., 2009; Barak & Grohol, 2011). Updates to Internet bandwidth able to compress audio and video files in real time are making this a more viable therapeutic alternative (Alcaniz et al., 2009). Interface changes to increase the friendliness of this platform are on the horizon to increase consumer acceptance and usage (Alcaniz et al., 2009).

### **Limitations of E-therapy**

As a new therapeutic modality online therapy needs leadership and professional boundaries to guide professionals who choose to use this service (Barak et al, 2009). Clients will also benefit from transparency of information regarding privacy, confidentiality, insurance coverage and provider qualifications.

Illiteracy or low reading ability continues to affect 15% to 40% of the adult population in the United States according to 2014 research by Barrett & Gershkovich. This negatively impacts their ability to use some online therapy tools, however video can still be an appropriate option. Information from (Castelnuovo et al., 2003) highlight concerns that this field, especially text based therapy, would only be accessible to a more educated population. This goal of online services is to expand treatment and reduce gaps in treatment availability, not to create another cultural divide in mental health services.

**Ethical Considerations**

Codes of ethics and guidance from professional boards, social work, psychology, and marriage and family therapy, need to keep up with the pace of technological advancements. Some providers are unsure how to ethically operate in this changing environment and are opting out versus moving ahead.

The National Association of Social Workers (NASW) in 2007 published practice standards for e-therapy modalities. The NASW, 2007 information cautions social workers to exercise additional caution when providing services without face-to-face contact. E-therapy practice has additional pitfalls for harm potential or abuse of vulnerable populations.

Research by Alleman in 2002 noted that the American Counseling Association (ACA), American Mental Health Counselors Association (AMHCA), National Board for Certified Counselors (NBCC), and the American Psychological Association (APA) also issued ethical guidelines for online therapy between 1997-2001.

**Privacy and confidentiality**

Confidentiality was cited by Wodarski & Frimpong as one of the top reasons social workers chose not to use email communications to provide services to their clients. Due to the many recent data breaches in retail and financial services it is understandable that providers would exercise caution with their clients sensitive information. These breaches may give clients the pause needed to exercise caution and put up with a few additional security hurdles to protect their personal information. Some clients may be unwilling to log in to a different website to decode their therapists email or install an encryption program on their computer. They may think that using a pseudonym will protect them (Alleman, 2002).

The Health Insurance Portability and Accountability Act (HIPAA) legally requires providers to offer secure telecommunication service to their clients (Maheu, 2003). Options exist to provide secure services, providers need to look in to these options themselves or advocate for more research and guidance from their professional organizations. Secure options for email, to reduce hacking risk include encryption, secure chats and Secure Socket Layer according to research by Santhiveeran in 2009. In 2000 the AMHCA's (American Mental Health Counselors Association) code of ethics advised using encryption to secure client personal health information. Encryption allows emails to be sent, typically through an encryption program and only opened when a user is signed in to that secure site (Alleman, 2002).

Online video services are usually enabled by a secure network or website to ensure information privacy (Barak & Grohol, 2011).

Online therapy practices offer client protection using credential verification. These larger online practices are easier to find in an Internet search. These organizations also handle secure communication connections, data storage (Barak & Grohol, 2011; and Finn & Bruce, 2008). However, concerns have been raised about the quality and stability of these organizations, crisis client procedure, mandated reporting, licensure double check, properly processing credit cards (Barak & Grohol, 2011).

### **Treatment appropriateness**

Alleman (2002) asserts that some mental health diagnoses are not appropriate for online treatment. Clients who are actively suicidal need crisis stabilization instead of distance therapy. Diagnoses where clients have trouble separating reality from fantasy such as thought disorders are also not advised. Anorexia and bulimia where clients physical symptoms are pertinent to view in order to direct appropriate interventions.

**Financial/insurance coverage**

Insurance coverage for e-therapy or virtual visits is one of the largest hurdles to telemedicine usage. According to research by the American Telemedicine Association published in September 2014 there is a wide variation of coverage and reimbursement by insurance providers and states. Nineteen states and the District of Columbia have full parity for private insurers, same coverage and reimbursement level for telemedicine as in-person visits. An additional two states have partial parity, which still provides coverage and reimbursement at in-person rates, however covered services are limited and usage is restricted to rural or underserved areas. State Medicaid is yet another story, 47 states have some telemedicine coverage, yet three states have zero coverage for telemedicine services.

Another limitation is the services must originate and be fulfilled at a certified coverage site. These are typically hospitals, doctors offices, nursing homes, and the patient's home as an example. However, not covered site examples are a hotel room (if you happen to be traveling), work or school which is a detriment to access and usability (American Telemedicine Association, 2014).

Types of communication authorized for coverage is limited in 49 states. South Dakota is the only state allowing the full spectrum of electronic communication options - interactive audio or video, still images known as store-and-forward, remote patient monitoring, e-mail, fax, or voice mail. Six additional states, including Minnesota, have coverage for synchronous technology, store-and-forward images, and remote patient monitoring. Four states completely ban the use of cell phone video as a method of service delivery (American Telemedicine Association, 2014).

Coverage restrictions based on distance and geography was a previous hurdle for telemedicine services. Currently, Ohio and Utah are the only states with distance requirements. This data suggest that erasing distance requirements highlights the use of telemedicine in areas beyond rural America (American Telemedicine Association, 2014).

Mental health providers eligible for reimbursement for telemedicine include a physician, clinical nurse specialist, psychologist, marriage and family therapist, clinical social worker, clinical counselor, substance abuse counselor, behavioral analysts (autism treatment). Commonly covered mental health services are diagnostic assessments, substance abuse treatment, counseling, medication management, and collaboration (American Telemedicine Association, 2014).

Video therapy sessions most closely resemble an in-person session which also influences the cost. Time intensive web therapy or synchronous email or text sessions generally command a similar price to an in-person therapy session (Barak & Grohol, 2011).

A majority of online therapy services are provided as fee for service (Barak & Grohol, 2011) as most private insurance plans reimburse at such a low rate. Providers deserve to be adequately compensated for their time and expertise, by clients and or insurance carriers (Barrett & Gershkovich, 2014).

### **Licensure**

The International Society for Mental Health Online (ISMHO) advised in 2000 (IMSHO, 2000 cited by Alleman, 2002) that providers treat only clients in the state in which they, the provider, is licensed. While an understandable way to navigate a new licensing and reimbursement challenge this would significantly curb the growth and appeal of online therapy services.



Menon and Rubin found in 2011 a majority of their respondents treated clients only within their license boundaries, additional respondents provided services in all 50 states and a few more provided therapy internationally when clients did not have access to an English speaking therapist.

Online providers are encouraged by the IMSHO to have a link on their website to their licensing entity. This will enable clients to obtain licensure verification information and alleviate scams or client anxiety (Alleman, 2002). Rummell and Joyce found in their research that 35% of online therapy providers did not disclose their credentials and another sample indicated a majority of providers had NO mental health training or degree. This writer was able to verify the licenses of social workers and marriage and family therapists in the Minnesota area and also obtain any information regarding disciplinary action. Psychologists were not verifiable online, but through a paper submission form. Empowering clients to know how to find this information is a crucial educational component of online therapy.

### **Therapeutic Relationship**

The therapeutic relationship is one of the key foundations of face-to-face therapy. It is considered a significant reason clients do or do not continue with therapy to achieve therapeutic goals and symptom reduction. A study by Carlbring et al indicated clients established a therapeutic relationship even with no eye contact. Clients further indicated it was beneficial to their ability to disclose personal and perhaps controversial information without direct eye contact.

Behavior on Internet websites varies from offering heartfelt support to strangers, forming romantic connections, advice on doctors and movies to scathing critiques of Twitter posts, angry rants on website forums and cyber bullying. This is a glimpse of the

spectrum of online disinhibition. Benign disinhibition describes people who exhibit unusually kind and sensitive behavior towards people they do not know. However, toxic disinhibition is what fuels the belief that you can behave in a way completely differently in an online context than in the real world. Anonymity and dissociation strongly contribute to the toxic disinhibition behavior (Suler, 2004).

Online disinhibition was found to have a positive effect on client behavior when Zarr began studying e-therapy in 1984. A client interview program for suicidal patients found they expressed themselves more fully when perceiving no judgment from the computer interviewer. Disclosing societally deviant thoughts like suicide to another human can be challenging. Again, the more sensitive the information, disclosing to a human is harder. Information gathered by Suler cites continuous feedback as shaping behavior which includes moving behavior back to societal norms. Anonymity changes that dynamic and creates a freedom to express yourself (Menon & Rubin, 2011) with no perceived judgment.

Sucala, Schnur, Brackman, Constantino & Montgomery, 2013 data showed 71% of therapists believed the therapeutic relationship was extremely important. About 47% of these therapists were confident in their relationship building skills in a new online environment. Providers were worried about reading patient cues, adequately monitoring clients' therapy progress, communicating caring and warmth and that this may damage the therapeutic alliance.

### **Training**

Early literature opinions minimized the need for additional training for online therapy delivery. Castelnovo et al., 2003 indicated therapists can move from in-person to Internet delivery since the focus of treatment does not change, it is still rooted in basic

therapeutic principles. While this is true, additional research highlights movement from in-person to online is not as seamless as some might have assumed. Effective online clinical skills come from a strong ethical, counseling skillset in face-to-face therapy (Murphy, MacFadden & Mitchell, 2008).

Providers utilizing online therapy must skillfully transfer their in-person tools and knowledge base to the online world (Carednas, Serramo, Flores & De la Rosa, 2008). Options suggested in their research include learning and adapting techniques from therapeutic reading and writing, or bibliotherapy.

A Mexican undergraduate training program offered 3 semesters of training specific to online therapy in mental health practice. The initial semester involved training in the use of online therapy, interventions, treatment skills based on a problem-solving model, and software support training. The final two semesters involve supervised practice. The supervision involved individual as well as group support. Students are consistently evaluated and supported through the learning process. The patients in this study indicated webchat provided sufficient interaction with their therapist. They also endorsed satisfaction with the convenience of online services and good quality communication even through email. Providers were excited to use a modality lower in cost and able to support more clients in volume and varying locations (Cardenas et al., 2008).

Providing e-therapy training during graduate studies would be particularly efficient. A training program developed for Worldwide Therapy Online, Inc. offers an online certificate program to graduate and post-graduate students and some exceptions to students with a combination of education and work experience. The program is entirely online comprised of e-lectures, weekly quizzes, and online counseling skill trainings

(Murphy, MacFadden & Mitchell, 2008). Use during internships and support in the classroom would increase practitioner confidence in technology use (Wodarski & Frimpong, 2013). Ongoing continuing education credit refresher sessions would also benefit providers and clients alike.

Lack of non-verbal cues to rely upon makes additional e-therapy training necessary to develop additional skills to communicate a warm caring personality using text (Rummell & Joyce, 2010). These cues provide important information for both provider and client as found by Barak & Grohol's 2011 research. Online therapy requires a new set of skills which need to be developed through additional classes and training (Barak et al., 2009; Midkiff & Wyatt, 2008).

### **Access – digital divide**

As of 2013 Internet use data provided by Pew Research shows 91% of the American adult population has a cell phone plus 56% have a smartphone. The top three usage categories are talking and texting (81%), Internet usage (60%), and sending or receiving email (52%). This information demonstrates the viability of e-therapy via smartphones (Pew Internet study 2013). Even though smart phone use rates are still positively correlated with education level and income a higher percentage of minorities endorsed having a smart phone versus white respondents.

While mental health providers seek to improve their own access to Internet connections and technology hardware it is important to remember not to leave anyone behind, including our own clients. The NASW, 2007 encourages social workers to advocate for not only themselves, but their clients to further access to high-speed internet. A Virginia study discussed by Wodarski and Frimpong showed 99% of social workers had Internet access and used it to work with their clients. Advocating for the rights of all

people to access the Internet, is an important social justice initiative (Wodarski & Frimpong 2013).

Currently, new emphasis includes laying high-speed or broadband cables. There is disagreement as to whether basic access for all residents should be increased or high-speed for a few should be the focus (Moylan, 2014)

### **Risk management**

Client decompensation is a risk even in face-to-face therapy sessions. Safety planning is always best practice and online therapy is no exception. It is particularly important to have resources in place if your client does not live in your area. The provider needs to know how to reach emergency personnel or crisis services wherever their clients are located.

Liability or malpractice insurance may have gaps in their coverage for online therapy. Providers need to understand what their policies cover and fill in any gaps in coverage (Maheu, 2003). This is an additional burden that must be accepted by providers participating in online therapy.

### **Informed consent**

Twenty three states require verbal or written informed consent before telemedicine services can be provided (ATA). The ACA and research by Maheu in 2003 advised that known limitations or challenges in online therapy must be part of a client's informed consent paperwork. It is further advised that if a client refuses to sign an informed consent they should be referred to in-person therapy (Alleman, 2002). Signature options can now include a digital signature after the 1999 passage of The Digital Signatures act (Midkiff & Wyatt, 2008).

**Conclusion**

Research by Wodarski & Frimpong (2013) indicates that the benefits of using e-therapy outweigh identified concerns when compared against no access to treatment. Client treatment for mental illness is better than receiving none due to access barriers.

Some early research thought of this new modality being just a novelty and was only regarded as appropriate treatment when used as a supplement along with traditional therapy services (Castelnuovo et al., 2003). However, other researchers see efficacy as a stand-alone service, especially when no other mental health services are available (Wodarski & Frimpong, 2013).

Treatment incorporating e-therapy is a cost-effective, time saving option for increased client access to their provider. Initial investment in technology and training will have positive long-term implications for agencies, providers and clients alike (Wodarski & Frimpong, 2013).

Research predictions from the early 2000's regarding future use of the Internet in online therapy pales in comparison to the actual advancements that have occurred due to availability of high-speed Internet (Barak & Grohol, 2011). However, these advancements would not be relevant if mental health professionals had not seized the opportunity to further online therapy treatment (Barak & Grohol, 2011).

Opportunities to create legitimacy and trust in this emerging practice - Continuous research (Barak & Grohol, 2011), institutionalized training (Barak & Grohol, 2011); Cardenas et al., 2008, Murphy, McFadden & Mitchell, 2008), updated ethical guidelines by each board (Barak & Grohol, 2011; Midkiff & Wyatt, 2008; Rummell & Joyce, 2010), vetted provider online directories (Barak & Grohol, 2011; Finn & Bruce, 2008), insurance reimbursement and cost benefit analysis (Barak & Grohol, 2011)

Efficacy of online therapy has been well researched. Many studies since the 1990's have debated this new frontier in psychotherapy. A meta-analysis by Barak et al, in 2008 showed efficacy in numerous studies that applied a therapeutic intervention. However, the efficacy is only as good as the provider or program. Inadequate treatment may worsen mental health conditions (Castelnuovo et al., 2003).

Providers fear that online services will render their services obsolete (Barrett & Gershkovich, 2014). This remains, very much, untrue at the present time. Online therapy is another therapeutic option for clients, not the only option. A vast majority of the online options still need therapist involvement or facilitation. Often therapy services continue to be delivered in-person or with a combination of email, text, phone or video support. A world without human therapists does not seem viable in the near future. This is the perfect time to seize innovative capabilities and create new tools to meet the demands of the changing therapeutic landscape (Barak, et al, 2008).

### **Conceptual Framework**

This qualitative study was viewed through the Systems Theory lens. Current systems are designed for traditional face-to-face therapy in a fee for service model.

The new field of e-therapy must change existing insurance systems to facilitate coverage for this service and adequately reimburse providers. New trends in Accountable Care Organizations ask health care systems to provide a continuum of care to their assigned client population. This type of insurance plan financially rewards positive outcomes through wellness and preventative care. E-therapy offers opportunities to encourage preventative care and more patient access to providers and services. E-therapy is a new tool to address system financial pressures due to the possibility of increased usage due to decrease in stigma, lower brick and mortar costs and reduced failed appointments.

Insurance enrollment is another current practice which needs to shift to move this concept forward. Providers only qualify for reimbursement if services are in-person, and both parties must be in the same physical location. Insurance reimbursement is also controlled by a providers state license. A practitioner must only provide services in a state where you are licensed. If a provider practices outside of their licensed state there will be no coverage or reimbursement by insurance companies.

Licensing is another significant systems issue. Currently, state licensing laws govern whether providers can provide e-therapy to clients physically located in their state or in other state. The state laws so far say all services must be within your licensing state. National licenses may be an option, however this would be a large system shift.



### **Methods**

This study utilized qualitative methods to gain insight in to how therapy providers decided to incorporate online therapy in their mental health practice. Using a qualitative study allowed inductive interpretation of the data. The literature highlights several limitations or concerns with online therapy, such as privacy and confidentiality, risk management, insurance reimbursement and fees, and establishing a therapeutic relationship at a distance. The research did identify some of the same concerns, as well as bringing forward new issues.

### **Research Design**

Grounded theory was the framework guiding this research project. Identified issues have presented themselves in the literature review, privacy and confidentiality, treatment appropriateness, licensure, and insurance coverage, among others. This literature information, regarding online therapy in social work practice, was the basis of survey questions for the respondents. The grounded theory approach allowed this researcher to formulate questions to guide the research, however, the researcher continued to be open to where the data and respondent information actually took the research. The qualitative data from respondents was analyzed, compared and contrasted with research information during the coding process (Padgett, 2008) this allowed themes to appear and funnel the research through the analytical process.

### **Sample**

This researcher's goal was to interview between eight and ten master's level Social Workers who work in direct clinical practice. The research study only yielded two participants. Both subjects are practicing MSW, LCSW's and offer online and in-person psychotherapy in their practices. Additionally, one provider is also a Certified E-

therapist in the State of Florida she has been in practice for 25 years. The second participant has been practicing for 7 years. Online therapy was a new platform for both interview subjects, they have been practicing in that format for 3 to 5 years.

This study involved subjects who were recruited using a purposive sampling process (Padgett, 2008). This topic involved assessing how direct clinical practice social workers began incorporating online therapy in to their practice. This study did not use a convenience sample as this technique does not discriminate between subjects and may recruit providers unfamiliar with online therapy use in direct practice (Padgett, 2008). It was important to interview therapists who already utilize this online modality in order to gain their information and insight about its use in a therapy practice. This purposive sampling distinction allowed the researcher to gather information about the clinician's use of online therapy from a knowledgeable interviewee.

Study participants were recruited using online therapy websites. The websites used to recruit these providers were [virtualtherapyconnect.net](http://virtualtherapyconnect.net), [inyourcorneronline.com](http://inyourcorneronline.com), [mytherapy.net](http://mytherapy.net), and [online-therapy.com](http://online-therapy.com). A total of 29 providers were contacted with multiple emails requesting their participation. Since the websites were online this allowed the researcher to gather information from providers outside of the geographic area to gain a different perspective on views. Snowball sampling (Padgett, 2008) from these clinical therapists who implement online therapy was considered. The initial screening tool for participants was to establish whether the clinician provides traditional therapy services in addition to online therapy or just online therapy. Selecting participants from an online therapy website may have meant the provider recruited potential clients from the site, but only provides in-person sessions. Research from the literature review suggested these therapeutic approaches have unique skills needed to be a

proficient provider in either area (Barak et al., 2009). The interviews took place via online video as both providers live outside of the State of Minnesota. The first interview was conducted using Skype with a provider in New York City. The second practitioner, located in Florida, used her own secure website which is hosted through CounSol.com.

Additionally, this study focused on which of the identified online therapy options these providers utilized. Each online therapy mode has distinct benefits and challenges associated with them. Insight relating to how providers chose which online modalities to use, independently or in combination with each other are important to this research study. Research suggests online therapy as a supplement to traditional psychotherapy offers increased therapeutic benefits (Wodarski & Frimpong, 2013).

### **Protection of Human Subjects**

A study participation consent form was created following the guidelines of the St. Catherine University Institutional Review Board (IRB) (See Appendix A) under the guidance of Dr. Rajean Moone, PhD, LNHA. The interviewee verbally consented to participate in the research study and signed the consent form at, or before, the time of the interview. The interviews were conducted and both lasted between 35 and 60 minutes. Interview locations were via video chat. The location was determined after respondent selection and based on their physical location. Video chat was used in a secure format to ensure information privacy. Interviewee's were compensated with a nominal \$10 gift card for their participation in this study. All interviewee's were informed that the interview would be recorded, and fully transcribed for use in this research paper. Confidentiality of their information was described in the consent form. The consent form outlined that the interview recording, transcription (both electronic and printed) and signed consent form was stored on this researcher's personal computer and recording

device under password protection. All forms, recordings, and transcribed information will be destroyed on September 1, 2015. There were no identified risks with the content of this research. Also, there were no identified direct benefits to participating in this research project. A copy of the consent form was given to each participant. All areas of the form were reviewed to ensure informed consent (Padgett, 2008).

### **Data Collection Instrument and Process**

The questionnaire was developed by the student to target information related to the research topic, and factors influencing providers' use of online psychotherapy. This researcher wanted to gain information about providers' knowledge about not only traditional psychotherapy, but online psychotherapy as well. Therapists have the choice to add online therapy tools to their clinical practice. Questions to capture information about why providers chose to add online modalities were included. The interview questions were worded as open-ended to encourage more dialogue versus closed-ended, yes or no questions. The flow of questions was designed from general knowledge to more specific and structured to have enough space for a free-flowing conversation and narrative (Padgett, 2008). All interviews were fully transcribed. The interviews are stored in the personal laptop of this researcher under password protection. The interview transcriptions, audio recordings, and signed consent forms will be destroyed on September 1, 2015.

The literature showed that online therapy is an emerging therapeutic modality and as a result more concerns and cautions are raised about its use in practice. This study gathered provider information regarding how they respond to the concerns identified in the literature. The prominent concerns were client privacy and confidentiality, therapeutic relationship, crisis planning, licensure, insurance reimbursement rates and

coverage, informed consent, and the technological astuteness of providers. A questionnaire reliability check will be performed between the graduate student researcher and instructor. A copy of the questionnaire can be found in Appendix B

### **Data Analysis Plan**

All interviews were fully transcribed by this researcher. After transcription all interviews were subject to the coding process. Grounded Theory influenced the data coding by using an inductive lens. Coding the participant interviews allowed the researcher to find themes and develop a coding structure. This lens allowed the data to freely influence and form the codes instead of data fitting into a preconceived code pattern. The transcribed interviews were read several times to identify initial phrases or ideas identified by the interviewees. A student researcher increased the study's rigor by reviewing the transcriptions and co-coding. After the co-coding the code words or ideas will be compiled in a codebook. The codebook was reviewed to develop larger themes, comparing and contrasting the information across all interview subject data. The research data was then compared and contrasted with the literature to see how the data answered the research question. The strengths and limitations of the research were identified and also compared to the research question. Additional implications for further social work research or policy were also be compiled.

The research attempted to answer how clinical social workers determined which e-therapy modalities to add in to their clinical practice, and how they mitigated concerns regarding client confidentiality and privacy, therapeutic relationship, crisis planning, licensure, insurance reimbursement and technology.

### **Findings**

The two providers interviewed offered a wealth of e-therapy advice for new practitioners and practical experience information. Major themes in the research were access and convenience, therapeutic connection, training and certification, technology, licensing, and HIPAA compliance. The providers agreed in their assessment that access to services increases with an e-therapy option. They also believe a therapeutic connection with clients can be formed even from a distance and with a barrier between them. They differed in formal training. One provider had a formal E-certification training, which she believed was extremely beneficial to her practice knowledge. However, the other did not have formal training or proactively seek out. Technology glitches and connectivity are still a concern, and the providers needed to have a fair amount of knowledge regarding technology to facilitate a session. HIPAA compliance and security of video sessions is a security and legal concern without substantial provider information.

Both participants were proponents of online therapy and enjoyed the e-therapy format. The only significant concern going forward was the licensing issue. If at a state and local level licensing was restricted to decrease access and availability for online services this would limit their ability to provide e-therapy.

### **E-therapy Mediums**

E-therapy mediums for the providers I interviewed included video or phone sessions, and journal entries. A majority of their e-therapy sessions are over video versus the phone. Typically, only if technology glitches occur do the sessions turn into phone sessions. As stated by one provider,

“I’ve done FaceTime before with people, but some people are just OK with sticking it out this way. It’s really a personal thing. I try to accommodate or even reschedule if they want. Usually they want to keep plugging away, stick with it.”

One provider indicated rural areas create their own connection issues and had this to say, “I still have a client up in Delaware who lives out in the country so we still get together over the phone.” The poor Internet speed makes video sessions extremely challenging. However, the providers did believe it was a valuable medium, “I think they’re both effective, even without the video I think you can still have a good session.”

The interviewees gave journaling mixed results. One provider has a journal as part of her web page. She believes it is a valuable part of the therapy process and allows clients to process things between sessions. “CounSol has a really cool thing too...a journal entry, where my clients can journal. Which extends the benefits of the session...they have a secure journal area as well.” She also frequently responds to clients and offers her feedback, “the website sends me a notification if I get an email or a journal entry. I’m pretty...I’m a bit OCD myself...I’m on there every day and I’ll respond on a daily basis.”

On the opposite end, the other provider finds the journal through her organization her least favorite format. “...has a diary option. Honestly, it’s my least favorite thing to do. It’s very time-consuming and I don’t think it’s very effective honestly. You’re not getting the back and forth and email is also very time consuming and it ends up not being worth your time so, I don’t do that either.”

Both providers began their careers providing therapy in an in-person format, then added e-therapy. This researcher asked whether having the in-person experience assisted in the format transition, the respondent stated:

“It might have been easier to...felt more natural. In the beginning it definitely took me awhile to get used to this. It was strange for me...but then later on I got more comfortable with it. I think I was so used to being in-person with people...I think if I had not had that first it probably would have been easier for me to jump on the platform and be comfortable with it.”

### **Experience and Training**

In-person psychotherapy was how both providers began their careers. They each had many years of experience providing therapy before venturing into the e-therapy realm. As indicated by one subject, “I had done some sporadic sessions here and there, but I hadn’t done it to get a lot of experience with it.”

One provider, with less overall therapy experience, began her e-therapy venture with no formal e-therapy training. She gained a significant amount of knowledge and experience from the other e-therapists in her practice, “there were people who had done it before who were offering tips. I would ask questions as I needed. It was more organic.” The more seasoned providers in this new practice were available and willing to share their tips and experience. When asked whether she would add e-therapy specific training she said, “I would certainly be open, I’m always open to learning new things. Things I haven’t thought of so if it showed up I would consider it.”



The other interviewee had more overall practice experience and had provided phone sessions, yet still sought out additional training to develop her e-therapy skills. She enrolled in Florida's e-therapy certification program and had this to say:

“You had to take an initial 20 CEU's and there wasn't a test initially. I think just completing and sending in proof of the continuing ed the 20 CEU's. I was already certified in the state as an addictions professional so it was treated like an auxiliary certification.”

This same participant had a significant background in computers and a consistent commitment to utilizing technology in her therapy and teaching professions. She found the certification program extremely beneficial and would highly recommend the additional training. She had a different level of knowledge regarding HIPAA and client connection issues than the other non-certified provider, stating:

“I think it's like going for your MSW and getting licensed. It gave me the education it gave me...you have to renew each year and get CEU's...just like being licensed and having to take ongoing education. You need to renew each year and get CEU's and I think it gave me a lot of good education, like this whole HIPAA thing and letting clients know you'll never hang up on them. All of these things came from the education I took in order to get certified. I think that a lot of the counselors using Skype and all really don't know...not that that's going to be a defense for them because it's not a defense. I really think they mean well, but they don't know they are breaking the HIPAA regulations. They just never took the courses in e-therapy to know some of these ins and outs.”

She also highly recommended choosing to take continuing education which is specific to e-therapy, "...take the continuing education...it is different than face to face you know the little nuances that you need to be aware of. I would definitely recommend the continuing education."

**Strengths of E-therapy****Accessibility and Convenience.**

Schedules for everyone are getting busier, “it allows people to actually go to therapy”, in the words of one provider. Many workers are traveling more for their employer, taking them out of the area and away from their providers. Other workers have less predictable schedules, healthcare workers, over the road truckers, service industry staff to name a few. “A lot of people will call me from their homes after they put the kids to bed. Even from work, if they are working late...you can do it anytime, anyplace.” Carving out one to two hours a week for a therapy session and travel time might be impossible for some clients. E-therapy provides an alternative. “I think you can reach more people, nowadays one more place to go...to see your therapist.”

Access to the mental health provider is an additional benefit, outside of the therapy session. One provider says, “...in fact I tell my clients you don’t have to wait until the next session. If you need anything, call, text, email.”

An unanticipated revelation was provider convenience. This format allows providers to adjust their work hours to provide flexibility for themselves and their families. “I really do enjoy the convenience aspect of it, it’s hard to give that up.” Additionally, it can provide needed income for providers instead of unpaid time off. “For me also I can go visit family and I still want to have a couple of sessions I can do that. I don’t have to be in NY to do sessions. That’s an added benefit, I can take it with me wherever I go.”

**Connection and engagement.**

Therapy success hinges on a relationship. The therapeutic connection can be just as strong using online therapy formats as it is in-person. “...In terms of establishing

rapport it's the same process. ...I feel like I still get a good rapport with people and they get value out of the experience. It's more than just the questions I'm asking, there's definitely a relationship." This connection is formed through between session connections using journal or diary options, in the words of one respondent:

"they can journal on issues they're working on...just as if they are in face-to-face when you ask a client to journal on what comes up for you this week on what we've talked about. Or I have a client going through a relationship breakup...journal on it instead of contacting the person...journal on it. We process through the feelings that way. I had another client who used it to write poetry because he was dealing with the grief over the loss of his mother. He writes poetry in the journal area."

The provider reaching out and even offering a free consultation to try things out, it was stated:

"...I just had a new person log on to my site. A new person registered and didn't set up an appointment. I sent an email through the site saying I saw that you registered...wondering what would be a good time to call you or let me know when you want to meet, I'll give you a free consultation. I offer free consultations."

The providers offer assurance that connection will be reformed even if the video or call drops, the participant said:

"I always let my clients know that if we lose each other for some reason I'll call. I'll never hang up on you, I'll never disconnect. I'll call you if we lose each other...it's a technical issue, it's not me hanging up on you. That's another area of concern...did my therapist hang up on me?"

Client identity was an initial concern, are clients honest about who they are? According to these interview subjects, their clients have proven to be sincere in their identities and their desire to make therapeutic progress using the e-therapy format. “I think that the folks that I work with are sincerely trying to achieve their goals.”

Some clients have had enough initial success with e-therapy, that they chose to begin in-person therapy. Initially, they were not comfortable using the in-person therapy medium, per the interviewee:

“There are people who would never do in-person therapy it would be too threatening for them, that in-person thing. It can be a bridge, their first experience with therapy and it takes the threat away and they say it’s fine. What was I worried about? Then they can go see someone in-person if they want. There are all sorts of myths about the therapy process...head shrinkers...people still have those ideas. I think tele-therapy demystifies it a bit in a good way.”

One provider noted clients who have made the switch from e-therapy to in-person. “A couple I’ve had ... have decided they wanted to (do in-person therapy)...not with me, because we were in different places, but they said they wanted to talk to someone in-person.”

Ultimately the person to person connection is the most important aspect. It can be formed successfully, even if it is from different geographic locations. The respondent indicated:

“It feels like there’s a wall, a window, because there is a window between us. For me it’s like what do I do with this wall/window, it’s in the way...I had to get over that myself and realize it’s the same thing and people were

actually...it was almost through just doing it and seeing oh people are actually having a positive (experience), it's working so I can relax"

**Provider Cost.**

E-therapy reduces the provider cost significantly. There is no office to rent, special furniture to purchase, or reception staff to hire. One provider uses Skype which allows no delivery cost. "Skype is free so there's no overhead." The other provider I interviewed did utilize a HIPAA secure site, which does have a cost, but it is significantly lower than a brick and mortar location. Still, both providers echoed the idea, "...for one thing, overhead costs are very low."

**Legitimacy and ethical considerations.**

The providers interviewed by this researcher were licensed clinical therapists. It is a misconception to believe they are not providing therapy to their clients. "It's like face-to-face," stated one provider. They have intake paperwork, consent forms, crisis plans just like in-person therapy. "I'm always accessible in case a client is in crisis, they can always contact me. There's the suicide hotline. Mobile crisis. 911. It's the standard, it doesn't differ too much from face to face."

The therapy process is the same, it is the delivery medium which is different.

"I get people's contact information ahead of time so if something does happen then I would know where they were. I can call 911 if something needed to be done. Of course I have my own crisis protocol if someone's going through something like a mental health crisis I can talk them off the ledge. Ultimately I want to be in a position where I can make sure they are going to be safe if needed."

**Limitations of E-therapy**

E-therapy is a new frontier in mental health service delivery. Initially, it was met with skepticism from one provider's clients, "I couldn't get clients to do the e-therapy. A lot of people were intimidated by the technology."

Also, even though it can be an effective medium for conducting therapy, it is a different experience for clients and providers alike. One provider did not want to be solely an e-therapy provider due to this difference. It was stated by one respondent:

"I don't think I would be a full-time online therapist. I always want to have the in-person part too. For me, it's valuable and also yes I think that you / I would miss a lot. I think this is therapy "light" I do think that's what it is. Can't really handle some serious stuff because of the risks...but just...because I don't really think it's going to be helpful to the client."

The therapy work is not as deep as in-person as over video or phone, per this provider. She believed it was a good option for less serious issues yet she would miss working with clients on a deeper level if she did not also have an in-person practice.

**Security.**

The security of our banking and financial information is constantly under fire from hackers. There have been several high-profile breaches at national retailers and banks within the past year. However, our medical and mental health information is also electronic and potentially at risk. One provider said:

"I definitely make sure people are aware of the risks. I say I cannot guarantee a purely secure connection. You're taking a risk...if you're ok with that risk then that's fine. Same thing with any correspondences...fyi this is on your own. You understand that this is as good as it gets so far."

Currently, depending on which provider you see, online clients are potentially taking risks with their private thoughts and mental health information. The other respondent indicated, "Skype is not secure. I can't meet my clients on Skype. It's a HIPAA violation actually. There's a lot of counselors using Skype...they're risking...to me it's an ethical risk that I'm not willing to take with my license. Because it's not HIPAA secure." Her E-certification course provided this information. Providers without that formal training or CEU's may not be aware of the security risks and how to manage them.

"The secured therapy sites that have to be HIPAA secure have just layers and layers of security where you can't break into the session. If we were on Skype anyone can break into our session. Whereas I think the session could be out there in cyberspace...um there's no guarantee if you're having a session talking about sexual abuse I mean that's just...with Skype it's accessible...it's just out there, it leaves a footprint and um with CounSol and virtualtherapy, there's just layers and layers of security on top of it where it doesn't leave a footprint...it doesn't leave a virtual footprint. Nobody can break into our sessions. Skype is free so there's no overhead. I'm paying to use CounSol. To me, it's worth paying for the peace of mind knowing I'm not going to harm anyone in terms of a security breach."

This insecurity is scary to practitioners and clients alike. On the other hand, people are accustomed to trading benefit for risk in an online arena. "I mean so far people don't seem to care or it's more important to actually get the therapy and give up the risks," were the words of one interviewee. People are able to prioritize the importance of access and convenience for complete security.



Although, as stated by another provider, written consent acknowledging the liability is needed by providers, "...because also we would need to have that in writing in order to protect yourself in case there was any kind of liability issue. I didn't want to get involved in any kind of liability issue." Her response to the security risks of Skype and other non-HIPAA compliant sites was, "I didn't want to get involved in any of that I said let me just find a site...let me research this and I'll get back to you." With a little help from a tech savvy friend, she found CounSol. She is able to securely communicate in a variety of formats, "CounSol has messaging. I think I had emailed you through CounSol. Again, it's secure and encrypted. Whereas regular email isn't."

### **Technology.**

Providers need expertise in computers to assist their clients when technical difficulties arise. "Sometimes if there's just a terrible connection and you can't proceed. I'll get their number and just call them or offer to reschedule. Most people want to just continue over the phone." Troubleshooting and problem-solving are natural skills for a therapist in the clinical setting, now they need to be applied to the Internet. This is a difference between an in-person appointment and a virtual appointment. How much of your e-therapy session is made up of non-therapy technical problem-solving? That may make an impact on connection and client willingness to continue in this format as stated:

"Sometimes on the website if I have too bad of a delay or too much feedback...I have one client in NY that every time I meet with her the feedback is just horrendous...I don't know what it is. She turns down her microphone and it worked a little better last time but what I've done when I've had technical difficulties with the audio is just call the person on the phone and we still see each other on the video...we would turn off our

microphones and just talk on the phone...we were still able to have visual contact.”

If the provider adjusts the session time to give the client their full session time it might be acceptable to the client. However, if the client does not have extra time, appointment over a lunch hour, this would be a downside to e-therapy.

One provider in particular was very savvy with technology. She stated, “I have always been a technology person.” It was natural for her to incorporate this format into her existing therapy practice, “...in another lifetime years and years ago I was a computer programmer, analyst. I’ve always enjoyed technology along with the counseling in one way or another...I have always been integrating technology into my work, so I guess this was a natural flow.”

Her technology skills were apparent as she really knew a lot about ways to optimize the connection and what might be causing a slow down or problem as evidenced in the following quote:

“I noticed you were getting some dings while we were talking. Do you have other applications open? Sometimes that has something to do with it too. I had a session with one client and I never had problems and we were having some problems...delay, etc. He said he was at home and his kids were using the Internet to play games so it interfered with our connection. He slowed down the connection on his side and messed up the interaction we were having. Sometimes other applications you have open at the same time or the browser like Internet Explorer is horrible. They say use Firefox or Chrome instead when you’re working online. It’s just a learning process to see what works.”

Both providers work through at least one, third party e-therapy site. One provider chose listings on several different e-therapy sites, yet provides all services through her hosted web page. “We tried the online with virtualtherapy, and Delaware is kind of rural...my clients had slow connections and it just didn’t work. We’d be talking and there’d be a delay...that doesn’t work well with therapy because you’re looking for a reaction and it’s not there.”

She did a significant amount of research to find a HIPAA compliant site and it also had many provider and client-friendly features. She had great things to say about the new site, “actually I use the website, CounSol has invoicing. So they get an invoice from the website automatically. It’s a really nice website, I really like it. Virtual Therapy didn’t have invoicing. They didn’t have the calendar for scheduling. This website...I really like it so far.”

### **Licensing restrictions.**

Currently, E-therapy providers must be licensed in the state where the therapy occurs, this is modeled on the current in-person licensing format. Essentially, both parties must be in the same state. One of the respondents had this to say:

“I’m licensed in NY, yes. Technically I work for a couple of different organizations, with Pretty Padded Room I am actually doing more “life coaching”, which isn’t state regulated what ever you would call it. The other organization I work for I work as a therapist but they definitely make sure you only work in the state where you’re licensed.”

“I don’t think it serves a purpose at all and I think it’s outdated and pointless. Having known a lot of therapists from all over, we’re all doing the same work we have all had the same training for the most part. I don’t

know the original reason was for that, I know there are different ways people get credentialed in different states but I don't think it needs to be. There needs to be more reciprocity a way for people to practice over state lines."

Licensing in this manner is an outdated format and a limitation for e-therapy providers. Both providers interviewed by this researcher were worried about how this would impact future service delivery as these issues are discussed and debated on a state and national level. She was very concerned about the social work licensing body and how they may or may not advocate for their members, "I'm afraid the NASW is just going to eliminate the ability to provide access to people in remote areas." In addition, she mentioned a startling licensing difference between therapy services provided by different degrees and licensures:

"My friend does e-therapy as a nurse. She's licensed as a nurse and she's also a counselor, but her license is a nursing license...she's licensed in like 10 states. ...the nursing license is not a big deal, you just pay your money and you can be licensed in all these different states. Whereas for us each state has a different requirement for a licensed clinical social work so this is going to be a mess unless we can all get on the same page and have the licensure be pretty much the same in every state and just get reciprocity."

According to her research there is only one state regulating e-therapy providers being located in the same state where their clients reside, "Right now there's no regulation about e-therapy other than CA that I've found so far."

**Personal connection.**

Even though it is possible to have a strong personal connection via e-therapy, it is admittedly different. “it’s definitely different you’re missing that vibe that you have. You still get a vibe, it’s not the same, I do prefer in-person therapy just in terms of the experience. Again there are also drawbacks, pros to the other.” Both practitioners admitted it can be challenging with technology challenges and signal delays. “it’s kind of weird when there’s a slow connection and a long delay it really interferes with the flow of the interaction.” This drawback was viewed as a limitation, but it could also be seen as just a difference between the in-person and electronic medium. “you kind of just froze up on me...stuff like that happens” It likely comes down to your perspective as to whether it is a factor which will limit your ability to connect or not.

**Insurance limitations.**

Both interview subjects did not work directly with insurance companies. One had this to say:

“I don’t work with insurance companies, because I have a part-time private practice right now. When I was full-time in Delaware I had a billing company that handled all of the insurance matters. I was on some insurance panels. I’m only part-time at this point so I don’t want to deal with insurance companies. I really don’t like working with insurance companies because they limit how you work with the clients. So I like to avoid insurance anyway. Because I don’t take insurance this seemed like a viable option because this way I can see people wherever they are, whenever it’s just kind of the way the world is going.”

A provider not billing insurance is a detriment for clients due to the out of pocket costs. These services will not apply to any yearly deductible, clients do not pay a lower insurance company negotiated rate, and the burden of any insurance submission is passed along to the client. As noted by this subject:

“...offers out of network reimbursement. There’s no actual, I don’t know if there are any insurances that accept teletherapy...I don’t know. The other company I work for they work on a contract basis with an insurance company. They take people from two specific insurances. For the most part I don’t know, I don’t do it and I don’t know if it’s possible to do it.”

These providers do charge less than an in-person session at a large healthcare organization. However, not all e-therapy providers are significantly less in cost because clients are paying for the expertise of the provider.

#### **E-therapy appropriateness.**

Non-verbal cues and subtle body language are missing from e-therapy. In the words of one subject, “people definitely bring a lot. I had a new client today and his girlfriend committed suicide so that to me is something you need to go see someone in-person for. I would not want to deal with that kind of a heavy issue on Skype therapy.” Deeper therapy work, which requires a strong, partnering, relationship is more challenging in an electronic format. Some situations or diagnoses were deemed inappropriate for this therapeutic format by both clinicians. The ability to use all of the therapists senses is beneficial in some therapy situations, “...the clients I’m working with right now in-person are they’re substance abuse clients and I’d rather they just come in and see me. So I can really get a feel for their level of sobriety and commitment.”

One of the providers did also say the clients she does not believe are appropriate for e-therapy due to their mental health severity. In her words,

“I think that there’s clients who are probably inappropriate for e-therapy or even difficult to work with face to face if you’ve got a borderline client.

I don’t normally work with borderline clients at all. Because it’s not a population I really want to work with. I think they would be a challenge online as well. Of course, there are other situations, people who have cognitive difficulties may not be appropriate to work with online.”

It also turns out these same clients are also clients she chooses not to treat in her in-person practice. “There are kind of people I weed out of my private practice as well in face to face. There is a certain type of client I like to work with face to face and online. I kind of pick those same folks to work with face to face and online because...face to face I don’t work with people under the age of 18. I don’t work with kids online or face to face. I don’t work with people with autism or learning disabilities it’s just not my area of expertise. I stick to my areas of expertise which are substance abuse and dependence, eating disorders, anxiety, depression. I kind of do the same thing online and face to face.”

The other provider framed her thoughts this way, “I do try to screen out people who seem, refer out, people who don’t seem like they’re really appropriate...or who could need some higher level of care, like who need to go see someone in-person.” She also tries to screen clients first to eliminate the need for referrals, if it is possible. Therapeutic bonds can occur quickly and starting over for vulnerable clients presents an additional challenge. One interviewee had this to say:

“I wouldn’t take on some clients in the beginning of course...anybody who has a trauma history or abuse history or suicidal past or something...anything really heavy issues like abuse or domestic violence or things like that. This is more counseling format versus a deep therapy format so breaks-ups, should I stay or should I go in this relationship, I hate my boss...stuff like that.”

### **E-therapy as a Valuable Format**

Continuing with e-therapy, even on a part-time basis was the answer from both providers. The question was proposed regarding whether there is something that would cause them to leave online practice, yet remain providing in-person. It is summed up in this provider’s words:

“I can’t really think of anything...probably the licensing issue. That would be the only thing that would interfere with the work that I’m doing, the licensing issue. Having to work only people in Florida or figure out how to get reciprocity in areas...states which is very costly and the way it’s set up, very time-consuming because each state has different regulations. I think that’s the only thing that would interfere with my working online.”

Neither provider had any past problem or issues which gave them pause when deciding to continue this online therapy format.

### **Separation of therapy mediums.**

Contrary to the flexibility and fluidity originally assumed, by this researcher, the clinicians interviewed did not mix their therapy modalities. “I like to keep them both separate. Maybe that’s just my preference. I do feel like it’s a different experience in-



person, I like to keep that in-person because I feel like that's a specific process we're going through." There was not crossover between in-person clients and e-therapy clients. This was an unexpected study result. One participant discussed that moving from electronic to in-person might be similar to having a preconceived or pre-created image of a person which is unfulfilled in reality. This can be distressing to the therapeutic relationship in the words of one participant:

"I do have a few people who live in NYC who could come see me hypothetically. I've just been doing Skype the whole time. I wouldn't discourage them, but what happens is it throws people off when they suddenly see you in the flesh and you're different. I think keeping them the same tends to work best for the client, the process. ...It can be too much for someone who's used to having you behind the screen."

## **Discussion and Implications**

### **Researcher Interpretation of Findings**

Online mental health services are a burgeoning field. An Internet search yields a dozen plus websites depending on whether you search for e-therapy, online therapy, or online counseling. People are choosing a different path to treat their stress and mental health issues using technology to their advantage. Many providers are adapting their therapy practice to serve this new client base utilizing technology. There were many salient issues brought forth in the research such as different e-therapy mediums, formal training and certification, licensing, connection between participants, convenience and access.

Research participants highlighted video or phone as the most prevalent forms of e-therapy they utilized. There were differing opinions between interviewee's regarding appropriate video formats. One provider routinely used Skype due to its ease and low cost. On the opposite side of the opinion scale, the other provider stated that Skype was a violation of HIPAA compliance and a security risk for sessions. The literature mentioned the burden for HIPAA compliance falls on the e-therapy provider. The legal ramifications of electronic media formats, asserted by one participant, were not discussed specifically in the literature. However, it appears wise for providers to do their due diligence to ensure they are legally protected in this new electronic format as well as the security of their client information.

Online journals or diaries had mixed participant thoughts. One provider strongly believed in the therapeutic relevance of journaling between sessions, the ability of the client to send their thoughts to her for feedback without waiting until their next scheduled session. Contrary to this thought was the other provider who did not believe this format

was therapeutically worth the time and expertise required for treatment in this e-therapy medium.

Formal e-therapy training was not discussed in the literature. Both participants were open to formal training, though only one participant had sought out formal e-therapy certification. The provider without formal training was open to future training, but did not see this as something missing from her current practice. To the contrary, the formally trained provider saw this as a significant different in practice abilities. This provider had additional information on securing sessions, HIPAA compliance and positively interacting with her clients electronically.

This researcher expected to find the e-therapy providers altruistically motivated to offer their services in an e-therapy format in an effort to increase access to mental health services. This was partially true. The providers interviewed did communicate that the e-therapy format increases convenience to mental health services for their clients. It is a portable service, able to be accessed at work, at home, or while traveling. Additionally, it serves an access need for rural and underserved areas as identified in the literature (Castelnuovo et al., 2003; Heinlen, Welfel, Richmond and Rak, 2003; Menon & Rubin, 2011). An unexpected finding, not mentioned in the literature, was the portability for providers as well. Providers are able to allow consistency for their clients even when they are out of town.

As referenced in the literature, a therapeutic connection can be formed via e-therapy. Both providers echoed the belief that their clients connected with them and continued to receive services due to this connection. One provider also believed e-therapy was a gateway to therapy services from a safe distance. Additionally one

participant confirmed what Alleman's 2001 research indicated, which is that some clients would not begin therapy if in-person services were the only option available.

Technology glitches and Internet connection still plague this new field. During both interviews I witnessed firsthand the challenges with frozen video images, garbled speech, and lost connections. While this was frustrating during an interview, it pales in comparison to divulging an important piece of information only to have no response or a request to repeat your statement due to volume difficulty. This is a startling difference between in-person and e-therapy formats.

Licensing was identified by both providers as a future concern for e-therapy. This field is moving faster than their current licensing bodies. While it is not currently limiting their ability to practice, they fear it may in the future if restrictions are not adjusted to respond to the new electronic therapy reality.

Session security and HIPAA compliance was primarily addressed by one provider of the two. Her formal E-certification provided an additional level of information and concern for using free video services such as Skype to conduct sessions. The assertion from this provider was that Skype sessions were HIPAA violations. While this may be the case, HIPAA compliance also mandates that clients are informed of a providers security measures and full disclosure of how your information can be accessed.

Insurance coverage and reimbursement continues to be a significant issue for e-therapy. If clients receive e-therapy treatment at a certified coverage cite, it will be reimbursed by Medicare or Medicaid. This is an additional burden for rural or low-income clients. The ability to receive services from the location of their choice is beneficial for all clients, not just higher income clients who can afford to pay on a fee for service basis. The literature discussed the limited coverage and payment structure for e-

therapy. Both providers interviewed choose not to work with insurance companies due to coverage and reimbursement rates. Unfortunately, this does not equate to a lower cost for privately paying clients as the provider expertise still deserves an adequate level of compensation (Barrett & Gershkovich, 2014).

As mentioned in the literature, some mental health diagnoses are not considered appropriate for distance, or e-therapy services. This concept was confirmed by the two study participants. They both identified more severe and persistent mental illness diagnoses, or borderline personality disorder as challenging to treat from a distance. One provider also treats chemically dependent clients and believes it important to see clients in-person to determine their level of sobriety and commitment to treatment. Some clients seeking treatment for significant issues may need a higher level of mental health care than an online session. The providers both seemed concerned about beginning therapy with a person they would not be able to treat in an e-therapy format.

### **Implications for social work practice**

Formal e-therapy education is a developing practice area. Currently, providers must be state licensed to practice in-person therapy, yet no requirements exist for e-therapy. E-therapy is very similar, yet there are differences to an effective online practice. Formalizing the training in this format may strengthen the legitimacy of the profession. This legitimacy may encourage insurance coverage and reimbursement as well.

Technology is an integral part of e-therapy practice. It is incumbent upon providers to know how to navigate technology to facilitate e-therapy sessions. Internet speed and stability is currently a problem for sessions. Clients may not be educated

enough to know how to navigate session challenges. Providers need to keep the session connected in order to provide adequate session time to their clients.

Appropriate boundaries and provider self-care are always an important part of a therapy practice. In light of what may be increased access to providers via cell phone or email, it is especially important to establish and maintain boundaries with clients in this new format. Scheduling early morning or late night virtual visits may be appropriate flexibility for the provider and client alike. Nevertheless, it is important for providers to set appropriate boundaries to limit potential for over-extension and burnout.

### **Implications for policy**

The policy implications for this study focus on access to technology, connectivity, and regulation. Access involves two different areas, first, is access to hardware such as computers, tablets, or smart phones. In some cases there are socio-economic factors driving whether clients have the ability to access these needed tools. Free technology, such as a library computer is not in a private space, which would not work for a therapy session. The second access issue is high-speed Internet. Governor Dayton and President Obama, both have initiatives to bring high-speed connectivity to rural areas. This needs advocacy and policy reform to ensure all people in all areas are well served by technology. High speed Internet should not only be reserved for metropolitan areas or for the wealthy.

### **Implications for research**

E-therapy is a fast moving area of practice. Additional research ideas moving forward include information security, licensing and reimbursement. What constitutes HIPAA compliance? Further research in to how to assure providers are not exposing themselves to legal liability or their clients to a data breach is important. Social work

licensures are different at a state level and whether they can or should be granted reciprocity across all states is another topic. Would national licensing be applicable or beneficial to providers and clients? Insurance reimbursement is a significant challenge. While Medicare and Medicaid do reimburse, it is often with significant restrictions and low rates. Private insurance plans are more resistant to paying. Why is that?

### **Strengths and Limitations**

E-therapy is a newly developing psychotherapy format. This innovative area has not been significantly researched. A strength of this research project is it adds to the body of knowledge on this new topic. Currently, research information on e-therapy is limited yet, it is a growth field and timely information will help move this format forward. I believe there is a significant amount of concern for client access and privacy in this area. This research will aid providers with making e-therapy choices in their practice.

The limitations of this study include a small sample size and generalizability. This study only garnered two participants. While these subjects offered insightful, relevant information a larger pool of participants lends credibility to the information. Additional research subjects adds to the generalization of the research information to the larger population. The current study results are not able to be applied to a majority of practicing providers due to the extremely limited volume of information.

### **Conclusion**

E-therapy is a breakthrough medium of mental health practice. It is clear from the increase in client usage that this new electronic delivery format is breaking barriers to mental health treatment for many clients. It is incumbent on providers, licensing bodies, and insurance carriers to facilitate growth and safety in this new realm. New initiatives in

Internet connectivity by President Obama and state governments will also facilitate growth in this new technological medium. Providing additional access to needed mental health services for all clients choosing to access must be welcomed and supported by all mental health stakeholders.



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**APPENDIX A****CONSENT FORM  
ST. CATHERINE UNIVERSITY****Check your In-box, Incorporating E-Therapy into Practice,  
Social Worker Perspectives**

I am conducting a study regarding attitudes, knowledge, and clinical use of on-line psychotherapy. I invite you to participate in this research. You were selected as a possible participant because you are a clinical social worker who has incorporated on-line therapy in their clinical practice. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Kristine Strobl-Reichel, MSW Student, and Dr. Rajean Moone, Ph.D., LNHA, St. Catherine University/University of St. Thomas School of Social Work.

**Background Information:**

The purpose of this study is: a qualitative interview with professional social workers to gather information regarding their decision to incorporate e-therapy into their practice and their view of its efficacy. Additionally, asking how they address concerns of e-therapy including assuring client confidentiality and privacy, use of ethical standards in e-therapy, specialized training for e-therapy, licensure requirements, and risk or crisis management.

**Procedures:**

If you agree to be in this study, I will ask you to do the following things: participate in one interview with the researcher. This interview may be in-person, via phone, or video chat. This interview will be recorded. The length of this interview will be 60-75 minutes.

**Risks and Benefits of Being in the Study:**

The study has no inherent risks.

There are no direct benefits you will receive for participating in this study.

**Compensation:**

Compensation for participation in this study is a \$10 gift card.

**Confidentiality:**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include a recording of the full interview and a full transcript. The recording, transcript, and signed consent form will be destroyed on September 1, 2015.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University/University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until March 1, 2015. Should you decide to withdraw data collected about you will not be used. You are also free to skip any questions I may ask.

**Contacts and Questions**

My name is Kristine Strobl-Reichel. You may ask any questions you have now. If you have questions later, you may contact me at 612-220-5136 or Dr. Rajean Moone at 651-235-0346. You may also contact the St. Catherine University Institutional Review Board Chair, John Schmitt, PT, PhD, at 651-690-7739 with any questions or concerns..

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

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**Signature of Study Participant**

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**Date**

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**Print Name of Study Participant**

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**Signature of Parent or Guardian  
(If applicable)**

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**Date**

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**Print Name of Parent or Guardian  
(If Applicable)**

---

**Signature of Researcher**

---

**Date**



**APPENDIX B**

## Interview questions

1. How long have you been practicing psychotherapy?
  - a. Have you provided in-person counseling?
2. When did you start incorporating e-therapy in to your practice?
3. What electronic therapy modalities do you utilize?
  - a. Email
  - b. Videoconference
  - c. Phone
  - d. Text
4. What were some of the factors influencing your decision to add this modality?
5. When you started offering electronic therapy services did you have any specific training?
  - a. If yes, what kind & was it beneficial?
  - b. If not, do you believe specialized training would have been beneficial?
    - i. If so, how?
  - c. Was any training available?
6. There are many concerns about electronic therapy and I'm curious how you plan for and manage them:
  - a. Privacy and confidentiality
  - b. Crisis plan
  - c. Licensure
    - i. What are your thoughts on national versus state specific licenses?
  - d. Insurance reimbursement (only serve clients in your licensed state?)
    - i. Do you accept insurance?
    - ii. Fee for service?
  - e. Therapeutic relationship
    - i. How do you establish?
    - ii. Any challenges in your experience?
7. What is your contingency plan for technology glitches?
  - a. Have you ever needed to implement it?
8. Do you offer in-person psychotherapy in combination with online therapies?
  - a. Which combinations have you used?
  - b. Are some combinations more successful than others?
    - i. If so, which ones
  - c. Are some combinations less successful than others?
    - i. If so, which ones
  - d. Are there times you only use online therapy?
    - i. If so, why
9. Anything that would influence your decision to continue to offer online therapy?